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Express Scripts Provider Certification
Application Type: PSAO Credential

GENERAL INFORMATION: Date Completed: 04/16/2015

Check one: ☐ New Pharmacy Application — Date Pharmacy opened:

☐ Change of Ownership Application — Date ownership effective:

☒ Existing Pharmacy Application

Are you affiliated with a PSAO? ☒ Yes ☐ No — Name of PSAO: LeaderNet; 603

Are you affiliated with a GPO? ☐ Yes ☒ No — Name of GPO:

NCPDP: 5906372 — NPI: 1023363165

CHAIN CODE: — FEDERAL TAX ID: (If applicable) 451551391

Pharmacy Name: Accu-Care Pharmacy

Legal Name: Safety and Health Technology, LLC

Address: 4645 Hwy 6, Ste. J — City: Sugar Land — State: TX — Zip: 77478

County: FORT BEND — How long has pharmacy been at this address? 2 Years, 10 Months

Phone Number: 8329399052 — Fax Number 2813026317

Mailing Address *(If different from Physical Address above)*

Address: — City: — State: — Zip:

Remittance Address

(If different from Mailing Address above) — Name to be printed on check: Accu-Care Pharmacy

Address: — City: — State: — Zip:

Contact Person: Lynh Phan

Pharmacy Permit Number: 28027

OWNERSHIP / AUTHORIZED INDIVIDUALS:
Total # of Owners: 1

Owner First Name	*Middle Initial*	*Owner Last Name*	*Percent of Ownership*	*Owner Email Address*
Petrus		Herbst	100.00	licensing@accucarepharmacy.com

GOVERNMENT EXHIBIT 221 4:18-CR-368

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Other individuals authorized to sign on owner's behalf:

First Name	*Last Name*	*Email Address*

List names and license #s of all Pharmacy Applicant's Pharmacists and Pharmacy Techs

Pharmacist/Prescriber in Charge:	Lynh Phan	License #	33090
Pharmacist Name:	Tharun Philip	License #	53043
Pharmacist Name:		License #	
Pharmacist Name:		License #	
Pharmacist Name:		License #	
Pharmacist Name:		License #	
Pharmacist Name:		License #	
Pharmacist Name:		License #	
Pharmacist Name:		License #	
Pharmacist Name:		License #	
Pharmacist Name:		License #	
Pharmacist Name:		License #	

TYPE OF PRACTICE: Indicate the anticipated percentage of Rx volume in each setting

☒	Open Door Retail/Community	65.00 %					☐	Medicaid	%
☐	Closed Door/ Clinic Facility	%					☐	Medicare	%
☒	Mail Order	10.00 %	☒	Local 97.00%	☒	Out of State 3.00%	☐	Workers Comp	%
☐	Nursing Home/LTC	%					☐	340B	%
☐	Internet Pharmacy	%	☐	New	☐	Refills %	☒	Compounds 3.00	%
☐	Home Infusion	%						Ship to other states?	
☒	Self Administered Injectable/Specialty	22.00 %							
☒	Other	3.00 %					☐	Dispensing Physician	%

List Other: Compounding

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BUSINESS INFORMATION:

Federal DEA #: FA3312585 State Tax ID: 32043959124 State: TX

Medicaid #: _____ State: _____ Insurance Carrier: Pharmacists Mutual Insurance Company

If more than one state attach list:

Software Vendor: PK Switch Company: RSI

Pharmacy Website URL: N/A

Hours of Operation:

M-F 9:00 AM 5:30 PM Sat: _____ AM _____ PM Sun: _____ AM _____ PM

☐ Open 24 hrs

☐ E-Prescribing / Vendor: _____ ☐ Braille Labeling ☐ Emergency Services ☒ Handicap Access

☐ Drive-Through ☐ TTY (Hearing Impaired) ☒ Delivery Service/Mileage 25 ☒ Out of State

	QUESTIONNAIRE SECTION	YES	NO
1	**Are three (3) or more pharmacies covered by this application assigned the same NCPDP chain code?** *If yes, please list the NCPDP numbers and the applicable chain code:*	☐	☒
2	**Is this pharmacy an open-door pharmacy that fills prescriptions for all walk-in customers without restrictions?** *If no, please provide detailed explanation of pharmacy restrictions:*	☒	☐
3	**Do you maintain electronic patient profiles?**	☒	☐
4	**Do you review prescriptions dispensed for drug interactions?**	☒	☐
5	**Is the pharmacy equipped to submit claims electronically in the most current NCPDP format?**	☒	☐
6	**Are you currently affiliated with a buying group or co-op other than a PSAO (*e.g.*, GPO)?** *If yes, please list the name of affiliated buying group:*	☐	☒
7	**Has the pharmacy previously participated in an Express Scripts or Medco pharmacy network?** *If yes, when and under what name(s) and NCPDP number(s)?*	☐	☒
8	**Do you provide any special services or have distribution rights to any specialty medications?** *If yes, please provide a detailed description of services or specialty medications supplied:*	☐	☒

9	Has the pharmacy (or another pharmacy you have owned) been disciplined by a State Board of Pharmacy, government entity or any other regulatory authority (i.e. State or Federal DEA or State Medicaid Department)? *If yes, please provide explanation of action taken, board order letter, and any other supporting documents from the State Board of Pharmacy, government entity, or other regulatory authority.*	☐	☒
10	Have any of the pharmacists, pharmacy technicians, owner or employee(s) of the pharmacy been disciplined by the State Board of Pharmacy, a government entity, or any other regulatory authority (i.e. State or Federal DEA or State Medicaid Department) in the last 10 years? *If yes, please provide details and attach letter(s) of disciplinary action.*	☐	☒
11	Presently, or at any time in the last 10 years, has the pharmacy, its owner(s)/principal(s) or any of its pharmacists been the subject of a civil lawsuit or criminal prosecution involving fraud, deceit, deception or a similar offense involving moral turpitude? *If yes, please provide detailed explanation:*	☐	☒
12	In the last 10 years, has the pharmacy or any of its owners/principals filed for bankruptcy, reorganization, or made a general assignment in favor of creditors? *If yes, please provide detailed explanation.*	☐	☒
13	Presently, or at any time in the last 10 years, has the pharmacy, its owner(s)/principal(s), its pharmacists, or any of its employees been suspended or excluded by the Office of Inspector General (OIG) from participating in any federal or state health care program (e.g., Medicare, Medicaid, TRICARE) or by the General Services Administration (GSA) from participating in any government contract/services? *If yes, please provide detailed explanation including applicable dates:*	☐	☒
14	Have any of the owner(s), member(s)/principals(s), officers, or directors of the Pharmacy owned any other Pharmacy(ies)? *If yes, please provide a list of the pharmacies, their NCPDP number(s), and the names of the owners, entity member(s)/principal(s), officers and directors:*	☐	☒
15	Has the pharmacy ever changed names? *If yes, please provide a list of the previous name(s), NCPDP number(s) if different, and the date(s) the name changed:*	☐	☒

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16	Has the pharmacy ever undergone a change in ownership? *If yes, please provide a list of the previous owner's name(s), ownership dates, and NCPDP number(s) if different:*	☐	☒
17	Is the pharmacy a Medicare Part B Provider? *If yes, please provide the Pharmacy's Part B Provider Number:*	☐	☒
18	In the past three (3) years, has any vendor providing services, supplies or medications to this Pharmacy, been excluded from participation in Federal or state health care program or government contract, or been otherwise subject to any restriction by the OIG or other state or government agency? *If yes, please provide detailed explanation including applicable dates.*	☐	☒
19	Does the pharmacy have a separate designated area for patient consultation?	☒	☐
20	Has the pharmacy obtained any accreditations/certifications (*e.g.*, PCAB, ACHC, The Joint Commission, URAC, VIPPS, etc.)? *If so, please submit a copy of certification(s).*	☐	☒
21	Does the owner/pharmacist-in-charge currently hold any non-resident state licensure(s)? *If yes, please submit a copy of license(s).*	☐	☒
22	Does the pharmacy provide sterile compounding medications? *If yes please provide most current certification document* (e.g., PCAB, air flow hood/HEPA filtration, etc.).	☐	☒
23	Are you HIPAA or Hi-Tech Compliant?	☒	☐

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Indicate all languages other than English spoken by staff within this pharmacy and languages in which prescription drug labels can be provided:

Lang	Label		Lang	Label		Lang	Label		Lang	Label	
☐	☐	Arabic	☐	☐	Armenian	☐	☐	Cambodian	☐	☐	Chinese
☐	☐	Farsi	☐	☐	French	☒	☐	Hindi	☐	☐	Indian
☐	☐	Japanese	☐	☐	Korean	☐	☐	Mandarin Chinese	☐	☐	Russian
☒	☐	Spanish	☐	☐	Tagalog	☐	☐	Vietnamese	☐	☐	
☒	☐	Other	Serbian								

- I certify that each answer on this Provider Certification (including attachments) is true and correct.
- I agree to notify Express Scripts immediately in writing in the event of a change in the information provided which would make any part of this Provider Application untrue or inaccurate. I understand that failure to do so will be considered a breach of my Provider Agreement and could result in disciplinary action including, but not limited to, immediate termination of my Provider Agreement.
- I give Express Scripts, and its designee(s), if any, permission to contact any individual, company, organization, etc, including state and federal licensing agencies, as may be necessary to verify the information submitted herein and to ask questions about disciplinary action, the pharmacy's license, or any pharmacist licensed, employed by or dispensing prescriptions at the pharmacy.

Printed Name: Petrus Herbst

Signature: P Herbst

Title: Authorized Signatory

Date: 04/01/2015